BRONX PROFESSIONAL STANDARDS REVIEW ORGANIZATION: EXPERIENCES WITH AMBULATORY CARE REVIEW*

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The shared health facilities play a major role in the provision of ambulatory care in the Bronx. We currently have identified 60 such facilities. Based on detailed examination of statistically valid samples of records in a randomly selected third of the facilities, we estimate that an active (at least one visit in the past 18 months) registered population of 420,000 is being seen. This means, of course, that patients go to more than one facility because there are only an estimated 350,000 Medicaid-eligible people in the Bronx. Forty-nine percent of the patients interviewed said that they also used other sources of care, most frequently mentioned outpatient departments in the borough's hospitals. Some positive things can be said about these facilities.

The facilities are located close to the population served and are readily accessible, the only requirement for the patient is a current Medicaid card. An example of this ease of accessibility is the fact that 65% of pregnant women register during their first trimester of pregnancy for prenatal care, a far higher proportion than in any other provider setting I have reviewed. In general, pediatricians and obstetricians, mostly foreign born, are board eligible or board certified; this is not true of adult medicine where many have had minimal training and are American born. In our chart studies we have rarely encountered grossly abusive practices of overreferral or overordering of tests or procedures.

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When this does occur, it is limited to a few adult care providers and consists of procedures or practices where the physician gains personal financial advantage, e.g., electrocardiograms, chest roentgenograms, spirometry, and excessive scheduling of visits. Only the latter, a difficult thing to prove, is fairly widespread, and excessive tests characterize only two or three of the 30 some adult physicians we examined in depth. It would appear that the outcries of the city and state agencies during the early 1970s were heeded, in at least so far as grossly abusive practices are concerned. In some instances it was felt that provision of episodic care was acceptable, particularly in pediatrics. Because about 42% of patients make only one visit in 18 months to the facility, it is clear that a large part of the practice is episodic.

This, however, ends the list of positive features I can attribute to shared health facilities. Our major concerns center around the almost total lack of comprehensive care and the poor, marginally acceptable level of clinical care provided by most physicians and the grossly unsatisfactory care provided by a dozen or so.

The average facility provides services in adult medicine, pediatrics, obstetrics, and gynecology. Each service generally was provided by two to five part-time physicians who rarely have met each other, have no common hospital affiliations, and no common guidelines or policies for provision of care. It should be noted there is no difficulty in obtaining a hospital appointment in the Bronx. While most obstetricians and some pediatricians maintain hospital appointments, sometimes in other boroughs, the majority of adult care providers by choice do not. Even clinic assistants are frequently brought into the facility by individual physicians so that there is no opportunity to develop support regimens by an ancillary staff trained to assist in the provision of adequate baseline care: performing pediatric measurements, taking weights or blood pressures, checking on missing laboratory procedures, etc. Professional and administrative leadership are totally lacking and this is one major impediment to bringing about change.

We have approached assessment of the quality of medical care in two ways. We have conducted "baseline audits" which contain explicit criteria for the measurement of baseline workups, preventive measures, maintenance care for adults, children, and pregnant women.[2] These studies have been carried out in a multitude of provider types over the past years and, by virtue of a scoring mechanism, permit comparisons

between provider types. In all of the areas reviewed, except care to the preschool child, ratings in shared health facilities have been significantly lower than in neighborhood health centers, hospital outpatient departments, group practices or specialty programs such as Maternal and Infant, Children and Growth Program, etc.[3] Care to preschool children is not good, but, unfortunately, it was also at a low level in the limited number of other provider settings reviewed. The area that has caused us the most concern has been care of pregnant women, for 27% of the prenatal visits had no recorded blood pressures, 61% failed to include patient weights, and 49% did not record urine testing. Failure of the obstetricians in most cases to deliver the patient or to make arrangements with a hospital also contributed to fragmented and incomplete care.

Our second approach has been to have physician peers review cases of selected disease entities. Flow sheets are created by Professional Standards Review Organization nurses. When we had more staff, an explicit review was also undertaken by the nurses. The physician then answers a structured implicit protocol covering some 35 items which ends with his overall assessment of the care both of the specific problem and of overall care of the patient. This material has alerted us to the need for a second review if more drastic action is believed indicated, calling physicians in to peer conferences, and utilized in the presentation to official agencies for seeking restitution of funds or disqualification from the Title XIX program (only 1% of patients seen in shared health facilities are covered by Medicare).

The most serious problems have been found in adult practice. Most physicians we have referred for punitive action have been in this category. Problems have related to poor evaluation of presenting symptoms, poor follow-up of abnormal laboratory findings (all too frequently sufficient laboratory studies are not ordered), failure to obtain information on past care of patients and, above all, excessive and inappropriate use of medications. Two of our reviewing internists characterize these latter problems as: excessive use of antibiotics, use of nonsteroid anti-inflammatory agents in unconfirmed joint complaints, unjustified use of cimetidine for gastrointestinal symptoms in the absence of proven ulcer disease, inadequate treatment of hypertension, and the excessive use of psychotropic medications, with no clear definition of the reasons why.

Most pediatric care is episodic and related to acute illness. Screening procedures or monitoring of growth and development are minimal.

Medication usage in acute conditions has been a concern primarily because of polypharmacy, overuse of antibiotics, and the compounding of frequently antagonistic medications for minor respiratory or gastrointestinal problems. (Due to the joint efforts of the Bronx and Manhattan Professional Standards Review Organization, a temporary halt in payment for compounding has occurred and will result in projected savings of several million dollars a year in prescription costs.) There have been problems with children with chronic disease, in part due to the failure of providers to obtain information on care they may be receiving elsewhere and in part due to lack of any follow-up system to assure ongoing contact with the children who do primarily use the facility.

Obstetrical care is furnished at a low level. Gynecological practice is mainly limited to problems of vaginal discharge and lower abdominal pain. The etiologic diagnosis of these conditions is rarely undertaken; a label of pelvic inflammatory disease is given and "shotgun" therapy prescribed. For more minor problems, the lack of on-site microscopes precludes wet smears and leads to empiric therapy only.

Another specialty that has been present in almost all the facilities that have been studied is radiology. Here too, quality problems have been serious, ranging from inadequacy of the films to inappropriate overreadings by adult care providers and pediatricians. One of the areas of greatest concern has been the performance of gastrointestinal radiologic procedures and barium enemas without fluoroscopy and without the presence of a radiologist. To perform barium enemas in these circumstances is dangerous, to do a gastrointestinal series results in unsatisfactory films and unnecessary radiation exposure to the patient. In spite of repeated recommendations to the state agencies to change payment policies for these procedures, we have not been able to accomplish this objective to date.

I believe that major accomplishments have resulted from these reviews. The Bronx Professional Standards Review Organization has issued a series of guidelines for maintenance care in medicine, pediatrics, and obstetrics and for management of the more common diseases seen in these areas. Facilities have been offered a manual with a series of different record formats and a listing of the needs for each primary care specialty.[4] We have endeavored to provide linkages with area hospitals by naming a liaison person in obstetrics in each hospital and by providing the facilities details of the information required by hospitals.

We have also had agreement by the hospital medical record rooms as to the type of request form they would like to have from the facilities when information is requested. Although the general efforts to promote continuing medical education have probably not been successful, as is true in most cases, a few educational activities appear noteworthy. An example is the one-to-one technical assistance we have been able to provide both clinicians and x-ray technologists through a joint Professional Standards Review Organization - Health Systems Agency grant. In all probability, this one-to-one education is the most effective. Another effort that has had a numerical success was the Professional Standards Review Organization mailing to shared health facilities' pediatricians about a course presented at Bronx Lebanon Hospital, specifically addressing ambulatory care problems identified in shared health facilities. The attendance from the shared health facilities was impressive.

Our working relationships with the state have been good. I mentioned the impact on regulations relating to compounding practices and the failure to achieve similar results with gastrointestinal radiologic examinations. The state has given tacit approval to the care policies we have promulgated and has been most helpful in trying to address the problems we have encountered with individual physicians.

We have succeeded in identifying very poor practitioners and are on the way to resolving such problems. Of the 90 physicians we have reviewed in depth, about one third have been called into the Professional Standards Review Organization for peer-review conferences. Some of these have shown improvement on follow-up studies, some have agreed to discontinue criticized practices, e.g., reading chest films. About 14 physicians have been referred to either state and/or federal agencies for further action: disqualification, restitution of funds, or monetary fines. State disqualification from the Medicaid program has resulted in one case, and similar action is proceeding on three other cases in addition to federal sanctions. Our greatest impact in obstetrics has been that when we returned for follow-up review, the physicians had either stopped providing obstetrical care or had left the country or county. What this will mean to the volumes in the hospital outpatient departments or to the health of the patients is problematic at this time.

It should be noted that both the Professional Standards Review Organization and the state are handicapped by present inability to implement selective "sanctions" such as not paying for specific procedures

for specific providers, for prenatal care of those who have failed to improve, or for pediatric bills for comprehensive care when such care is not provided.

One further word on the poor practice of a small number of providers who are believed to be "impaired" primarily because of mental disorders. This has been a most frustrating situation, and no means are available to solve or even to approach these distressing cases at the state level. I specifically refer to the Office of Professional Medical Conduct.

As to the future, my crystal ball is not clear enough to tell me what will emerge for the Professional Standards Review Organization in ambulatory care review. One short-term impediment has been federal insistence on binding review in our Memorandum of Understanding with the state without acknowledging that this terminology translated from in-hospital experience would be unrealistic in view of the massive amount of services, the Professional Standards Review Organization's decreased resources, and the folly of duplicating efforts of state staff in surveillance of Medical Management Information System data.

In the longer term, official surveillance of ambulatory practice is essential. It is also essential to utilize a broad spectrum of physician specialists trained and experienced in the review process. Such physicians are far more likely to be found outside of the state system that may take over review activities should the block grant concept be implemented. I would urge that one of the best features of the Professional Standards Review Organization, the involvement of skilled local practitioners, be maintained.

REFERENCES

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